

A stylized, pixelated graphic of the American flag, showing the stars and stripes in a diagonal, wavy pattern, occupying the top left portion of the page.

Medicare & You

2003

**This handbook has important
information about:**

- Your Medicare benefits.
- Choosing a health plan that's right for you.
- Your Medicare privacy rights.
- New ways to get information.

**How do you find what you need?
See the Index on page 69.**



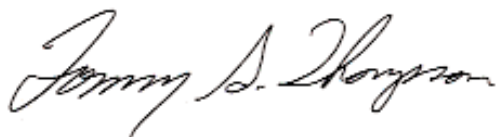
Welcome to *Medicare & You*

Medicare coverage is an important asset, and we are committed to helping you understand as much about your Medicare program as possible. This handbook contains valuable information about Medicare and is a good resource. Whether you are enrolled in the Original Medicare Plan, or in a Medicare + Choice Plan offered by a private company, we want you to have all the information you need to make the most of the Medicare services that you know and trust.

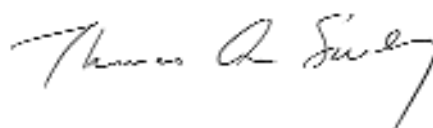
We are working to make Medicare easier for you by:

- ✓ **Expanding 1-800-MEDICARE (1-800-633-4227).** This 24-hour a day, seven day a week line is a BIG expansion of Medicare customer service - so you can ask about health plans, Medigap coverage, finding a quality nursing home, or any other Medicare coverage issue (see pages 62-63).
- ✓ **Providing Information on the web.** The website www.medicare.gov has vast amounts of information you can trust. We have included new QUALITY INFORMATION on nursing homes, kidney dialysis centers, managed care plans, and more. We are committed to expanding our quality efforts to give you the information you need to CHOOSE THE BEST HEALTH PROVIDER FOR YOU!
- ✓ **Expanding the “Medicare Personal Plan Finder.”** For the first time, you can compare the costs of the Original Medicare Plan plus Medigap versus Medicare + Choice (private health plans) to help you pick the right plan for you.
- ✓ **Helping You Find Programs that Pay Your Medicare Expenses.** States have programs to help people with low incomes pay some or all of Medicare’s premiums, deductibles, and copayments. For more information, see pages 58-59.
- ✓ **Helping You Find Programs that Pay for Prescription Drugs.** Some programs can offer discounts or free medications. Look at www.medicare.gov under “Prescription Drug Assistance Programs” or call 1-800-MEDICARE.

A strong Medicare program is critical to the health of our nation. President Bush has proposed some common sense changes, including a long overdue prescription drug benefit to strengthen and improve the program. We are committed to HELPING YOU HELP YOURSELF - and making the Medicare program work better for all of us.



Tommy G. Thompson
Secretary
Department of Health and
Human Services



Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

“Helping You Help Yourself”

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What's NEW in Medicare

New Quality Initiatives:

High quality and safe health care are important to everyone. In 2002, the Centers for Medicare & Medicaid Services (CMS) started reporting information on the quality of care in nursing homes. Information is currently available for Medicare health plans and dialysis facilities to help you choose high quality health care. Visit www.medicare.gov on the web. Select “Nursing Home Compare,” “Medicare Personal Plan Finder,” or “Dialysis Facility Compare.” Information about health plan quality is also available at 1-800-MEDICARE (1-800-633-4227). This 24-hour Helpline is available to help you with your Medicare questions. TTY users should call 1-877-486-2048.

New Information: 5 Steps to Safer Health Care (see page 4)

Information about Assignment (see pages 34 - 35)

Plan Benefit Option to Reduce your Medicare Part B Premium (see page 40)

Rules for Joining and Leaving Medicare + Choice Plans (see pages 41-44)

Notice of Medicare Privacy Practices (see pages 50-53)

If you have Employer or Union Health Coverage: Call your employer or union before you make any changes to your health coverage. Your employer or union may offer different plans from those described in this handbook. See page 55 and questions on pages 13-15 and 45 for important information.

If you are a Railroad Retirement Beneficiary: Call your local Railroad Retirement Board (RRB) office for answers to Medicare questions. You can find your local office by calling 1-800-808-0772. More information about Medicare for Railroad Retirement beneficiaries is at www.rrb.gov on the web.

If you need help paying health care costs: See pages 58-59 for information about state programs that may help pay your Medicare premiums, coinsurance, or deductibles.



If your address changes: Call the Social Security Administration (SSA) at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Important: The information in this handbook was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select “Publications.” Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if you have the most up-to-date version. TTY users should call 1-877-486-2048.

About This Handbook

- ✓ **Please Keep this Handbook:** This handbook is good (valid) starting January 1, 2003. Use it in place of any older version you have now. Keep it where you can find it if you need it.
- ✓ **Finding Information:** The index starts on page 69. This is an alphabetical list of what is in this handbook, with page number(s).
- ✓ **Words in Blue:** Words shown in blue are defined on pages 65-67.
- ✓ **Information is Available by Phone and on the Web:** You can get information and help with your Medicare questions 24 hours a day by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look at www.medicare.gov on the web for information about Medicare health plans, the quality of nursing homes, and prescription drug assistance programs.
- ✓ **Local Health Plan Information:** Details about the Medicare + Choice Plan choices in your area begin on page 77.
- ✓ **Sharing “Medicare & You 2003:”** Households with up to four people with Medicare will get one handbook to share. The handbook will be addressed to one person. This will help save Medicare money. If your household gets more than one handbook, you can choose to share one copy in the future. If you want to share, call and tell a Customer Service Representative at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Please have your red, white, and blue Medicare card with you when you call.

Medicare & You 2003 explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

5 Steps to Safer Health Care

1. Speak up if you have questions or concerns.

It's important to ask questions and make sure you understand the answers. Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers.

2. Keep a list of all the medicines you take.

Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbs. Tell them about any drug allergies you have.

Ask your doctor and pharmacist about side effects and what to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. Make sure you get the results of any test or procedure.

Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected in person, on the phone, or in the mail, don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4. Talk with your doctor and other members of your health care team about your options if you need hospital care.

If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5. Make sure you understand what will happen if you need surgery.

Ask your doctor, "Who will take charge of my care while I'm in the hospital?" Ask your surgeon:

- Exactly what will you be doing?
- How long will it take?
- What will happen after the surgery?
- How can I expect to feel during recovery?

Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia.



Section 1

The Medicare Program



Medicare is a health insurance program for:

- People age 65 or older.
- Some people under age 65 with disabilities.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Has Two Parts

Part A Hospital Insurance, see pages 6-7.
Most people do not have to pay for Part A.

Part B Medical Insurance, see pages 8-9.
Most people pay monthly for Part B.

Medicare Health Plans

Today's Medicare is about choice. Your health plan choices include:

The Original Medicare Plan -
Available nationwide.
For more information, see page 23.

or

Medicare + Choice Plans
(pronounced “Medicare plus Choice”),
including:

- Medicare Managed Care Plans
(like HMOs, see page 38).
- Medicare Private Fee-for-Service
Plans (see page 39).

Available in many areas.

The Medicare health plan that you choose affects many things, like cost, doctor choice, benefits (some have extra benefits, like prescription drugs), convenience, and quality (see page 20).

For help comparing your health plan choices, use the “Medicare Personal Plan Finder.” See page 21 for details.

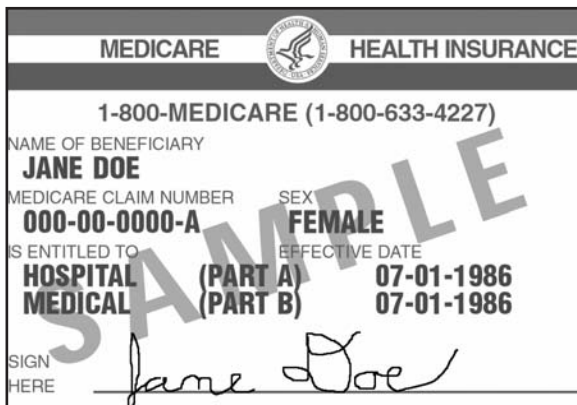


What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your **inpatient care** in hospitals, **critical access hospitals**, and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions.

Cost: Most people do not have to pay a monthly payment, called a **premium**, for Part A. This is because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card (see sample card below). If you have Part A, “Hospital (Part A)” is printed on the lower left corner of your card. You can also call the Social Security Administration at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.



A sample Medicare card for Jane Doe. The card is white with a blue header and footer. The header contains the text "MEDICARE" and "HEALTH INSURANCE" separated by a circular logo. The footer contains the text "SIGN HERE" and a signature line. The card displays the following information: 1-800-MEDICARE (1-800-633-4227), NAME OF BENEFICIARY JANE DOE, MEDICARE CLAIM NUMBER 000-00-0000-A, SEX FEMALE, IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B), and EFFECTIVE DATE 07-01-1986. A large "SAMPLE" watermark is overlaid diagonally across the card.

Do you need to replace your Medicare card? You can order a new Medicare card at www.ssa.gov on the web, or by calling the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Note: There are earlier versions of this card that are slightly different. They are still valid.



Medicare Part A Helps Cover Your:

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in [critical access hospitals](#) and mental health care. This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless [medically necessary](#).

Skilled Nursing Facility Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day inpatient hospital stay).

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Care: For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in your home. However, short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.

Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.

Note: Information about the costs for these services in the Original Medicare Plan is on page 25.



What is Medicare Part B?

* You may be able to get help from your state to pay this premium (see pages 58-59).

Medicare Part B (Medical Insurance) helps cover your doctors' services, and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are [medically necessary](#) (see pages 9-12).

Cost: You pay the Medicare Part B premium of \$54* per month in 2002. This amount may change January 1, 2003. In some cases, this amount may be higher if you did not sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it. You will have to pay this extra amount as long as you have Part B, except in special cases (see Q3 on pages 13-14).

Enrolling in (Joining) Part B

If you didn't enroll in Part B when you were first eligible, see Q3 on pages 13-14.

Enrolling in Part B is your choice. If you already get Social Security or Railroad Retirement benefits, you are automatically enrolled in Part B starting the first day of the month you turn age 65. If you are under age 65 and disabled, you are automatically enrolled in Part B after you get Social Security or Railroad Retirement benefits for 24 months. Your Medicare card will be mailed to you about three months before your 65th birthday or your 25th month of disability benefits. If you do not want Medicare Part B, follow the instructions that come with the card.

If you choose to enroll in Part B, the [premium](#) is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. In these cases, you **won't** get a bill for your premium. If you do not get any of these payments, Medicare sends you a bill for your Part B premium every three months. If you do not get your bill by the 10th of the month, call the Social Security Administration at 1-800-772-1213 or your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.



Enrolling in (Joining) Part B (continued)

Are you age 65 and still working? Thinking about delaying your Medicare Part B? See Q3 on pages 13-14.

If you are close to age 65 and are not yet getting either Social Security (or Railroad Retirement benefits) or Medicare, you can apply for both at the same time. You can also apply for Medicare only. You can sign up for Part B during your Initial Enrollment Period. It begins three months before the month you turn 65. It ends three months after the month in which you turn 65. If you wait until you are 65, or sign up during the last three months of your Initial Enrollment Period, your Medicare Part B start date will be delayed. To apply, you can call or visit your local Social Security office, or call Social Security at 1-800-772-1213. You may be able to apply at www.ssa.gov on the web if you meet certain rules. If you are a Railroad employee or Railroad Retirement Board beneficiary, call your local RRB office to apply.

Medicare Part B Helps Cover Your:

Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy.

Clinical Laboratory Services: Blood tests, urinalysis, and more.

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.

Blood: Pints of blood you get as an outpatient or as part of a Part B covered service.

Note: Information about the costs for these services in the Original Medicare Plan is on page 26.



Preventive Services to Help You Stay Healthy

Medicare Part B Covered Preventive Services

Who is Covered

Bone Mass Measurements:

Once every 24 months for qualified individuals and more frequently if medically necessary.

Discuss with your doctor to determine if you are a qualified individual.

Colorectal Cancer Screening:

Fecal Occult Blood Test - Once every 12 months.

Flexible Sigmoidoscopy - Once every 48 months.

Colonoscopy - Once every 24 months if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.

Barium Enema - Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy.

All people with Medicare age 50 and older, except there is no minimum age for having a colonoscopy.

Diabetes Services and Supplies:

Coverage for glucose monitors, test strips, and lancets.

Diabetes self-management training.

All people with Medicare who have diabetes (insulin users and non-users).

Certain people with Medicare who are at risk for complications from diabetes. Your doctor or other health care provider must request these services.

Glaucoma Screening:

Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.

People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African-Americans who are age 50 and older.



Preventive Services to Help You Stay Healthy (continued)

Medicare Part B Covered Preventive Services

Mammogram Screening:

Once every 12 months.

Medicare also covers new digital technologies for mammogram screening.

Who is Covered

All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.

Pap Test and Pelvic Examination (Includes a clinical breast exam):

Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.

All women with Medicare.

Prostate Cancer Screening:

Digital Rectal Examination - Once every 12 months.

Prostate Specific Antigen (PSA) Test - Once every 12 months.

All men with Medicare age 50 and older (coverage begins the day after your 50th birthday).

Shots (vaccinations):

Flu Shot* - Once a year in the fall or winter.

All people with Medicare.

Pneumococcal Pneumonia Shot - One shot may be all you ever need. Ask your doctor.

All people with Medicare.

Hepatitis B Shot

Certain people with Medicare at medium to high risk for Hepatitis B.

*** Why should I get a flu shot every year?** The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year.



Medicare Also Helps Cover:

- Ambulance services when other transportation would endanger your health (see page 18).
- Artificial eyes.
- Artificial limbs that are prosthetic devices, and their replacement parts.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation.
- Emergency care.
- Eyeglasses - one pair of standard frames after cataract surgery with an intraocular lens.
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Kidney dialysis.
- Medical nutrition therapy services for people who have diabetes or kidney disease (unless you are on dialysis) with a doctor's referral. The medical nutrition therapy services will be covered for 3 years after the kidney transplant.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral drugs for cancer.
- Preventive services (see pages 10-11).
- Prosthetic devices, including breast prosthesis after mastectomy.
- Second surgical opinion by a doctor (in some cases).
- Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners.
- Telemedicine services in some rural areas.
- Therapeutic shoes for people with diabetes (in some cases).
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at Medicare-certified facilities).
- X-rays, MRIs, CAT scans, EKGs, and some other diagnostic tests.



Common Questions and Answers

Q1: How do I get a new Medicare card if my card is lost, stolen, or damaged?

A: To get a new red, white, and blue Medicare card call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. Or, order a new card from SSA at www.ssa.gov on the web. Select “Medicare information.” SSA will send you a new card. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772, or look at www.rrb.gov on the web.

Q2: When do the Medicare premiums and coinsurance rates change? How will I know what they are?

A: New Medicare [premium](#) and [coinsurance](#) rates become effective in January. If you get Social Security or Railroad Retirement benefits, new rates are sent to you each December with your cost of living adjustment notice. You can also get the new Medicare rates for 2003 after December 1, 2002 by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227).

Q3: What if I didn’t sign up for Medicare Part B when I first became eligible?

A: If you didn’t sign up for Medicare Part B when you first became eligible (for example, because you were still working), you may sign up during the General Enrollment Period (see below) or the Special Enrollment Period (see page 14).

1. General Enrollment Period

This period runs from January 1 through March 31 of each year. During this time, you can sign up for Medicare Part B at your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772. Your Medicare Part B coverage will start on July 1 of the year you sign up. Remember, the cost of Medicare Part B will go up 10% for each 12-month period that you could have had Medicare Part B but did not take it, except in special cases (see page 14). You will have to pay this extra amount as long as you have Medicare Part B.



Q3: What if I didn't sign up for Medicare Part B when I first became eligible?
(continued)

A: (continued)

2. Special Enrollment Period

This period is available if you waited to enroll in Medicare Part B because you or your spouse were working **and** had group health coverage through an employer or union based on this current employment.

If this applies to you, you can sign up for Medicare Part B:

- Any time you are still covered by an employer or union group health plan, through your or your spouse's **current or active** employment, or
- During the 8 months following the month that the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

Note: If you are still working and plan to keep your employer's group health coverage, you should talk to your benefits administrator to help you decide when is the best time to enroll in Medicare Part B. **When you sign up for Medicare Part B, you automatically begin your Medigap open enrollment period.** Once your Medigap open enrollment period begins, it cannot be changed or restarted. For more details about Medigap policies, see pages 56-57.

If you are disabled and working (or have coverage from a working family member), the Medicare Part B Special Enrollment Period rules may also apply.

Remember, most people who sign up for Medicare Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible but do not sign up for Medicare Part B during the Special Enrollment Period, you will only be able to sign up during the General Enrollment Period (see page 13), and the cost of Medicare Part B may go up.

For more information about signing up for Medicare Part A and Part B, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.



Section 1: The Medicare Program

Q4: What happens if I took Part B at age 65 and then dropped it because I (or my spouse) was working and had group health coverage from my employer or union? Can I get Part B back without paying higher premiums?

A: If you had Part B, and then dropped it because you or your spouse were working and had group health plan coverage through the employer or union, you can sign up during a Special Enrollment Period to get it back (see Q3, #2 on page 14). Make sure that your group health plan coverage is in effect before you drop Part B. In this case, the cost of Part B will not go up when you get it back. Remember, when you drop Part B, your coverage ends the next month. Also, you will not get another Medigap open enrollment period when you restart Part B.

Q5: I currently have Part B but I (or my spouse) have returned to work and I now have group health coverage from my employer or union. What happens if I drop Part B?

A: If you drop Part B because you or your spouse are working and you have group health plan coverage, you can sign up for it again in the future during a Special Enrollment Period (see Q3, #2 on page 14). Make sure that your group health plan coverage is in effect before you drop Part B. In this case, the cost of Part B will not go up. Remember, when you drop Part B, your coverage ends the next month. Also, if you dropped Part B after age 65, you will not get another Medigap open enrollment period when you restart Part B.

Q6: I am under age 65 and have ALS (Amyotrophic Lateral Sclerosis), known as Lou Gehrig's disease. When can I get Medicare?

A: If you are under age 65 and have Lou Gehrig's disease (ALS), you get your Medicare benefits the first month you get disability benefits from Social Security or the Railroad Retirement Board. For more information about disability benefits, look at www.ssa.gov on the web. Or, call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board, look at www.rrb.gov on the web or call 1-800-808-0772.



Section 1: The Medicare Program

Q7: Does Medicare pay for prescription drugs?

A: The Original Medicare Plan does not cover prescription drugs except in a few cases, like certain cancer drugs. You should ask if the pharmacy is enrolled in the Medicare program (see page 35). Many [Medicare Managed Care Plans](#) under the Medicare + Choice program, cover prescription drugs, up to certain dollar limits (sometimes for an extra cost). Some [Medigap policies](#) and states also cover prescription drugs. For information about “Prescription Drug Assistance Programs,” look at www.medicare.gov on the web (see page 59). Or, call 1-800-MEDICARE (1-800-633-4227). You can use this to learn about different prescription drug coverage options, including Medicare Managed Care Plans and Medigap policies.

Q8: Does Medicare cover dental services?

A: Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. Medicare Part A will pay for certain dental services that you get when you are in the hospital. Call your local [Medicare Carrier](#) for more information (see page 76). Some Medicare health plans may offer additional dental coverage.

Q9: Does Medicare cover my costs if I am in a clinical trial?

A: Yes. Medicare pays for routine costs if you take part in an approved clinical trial. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe. It is important for you to ask what costs you will have to pay before signing up for a clinical trial. For more information about clinical trials, get a free copy of *Medicare & Clinical Trials* (CMS Pub. No. 02226). Look on page 64 for details about how to get this booklet.

Q10: What diabetic supplies and services does Medicare cover?

A: Medicare covered diabetic supplies and services include:

Diabetic Supplies: Glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes. There may be limits on supplies or how often you get them. You should ask if the pharmacy or supplier is enrolled in the Medicare program (see page 35).

Diabetic Services: Diabetes self-management training, medical nutrition therapy, foot exams, and glaucoma screening. You must meet certain conditions to be covered for these services.

For more information, get a free copy of *Medicare Coverage of Diabetic Supplies & Services* (CMS Pub. No. 11022). Look on page 64 for details about how to get this booklet.



Section 1: The Medicare Program

Q11: I have more than one insurance. How do I know who pays first?

A: Sometimes your other insurance pays your health care bills first and Medicare pays second. This is called Medicare Secondary Payer. Other insurance that may have to pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 64 for details about how to get this booklet.

Q12: What is a "private contract," and how does it work?

A: A private contract is a written agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract in an emergency or urgent care situation. If you sign a private contract with your doctor:

- Medicare health plans won't pay any amount for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you for the services you get. Medicare's [limiting charge](#) will not apply.
- Medicare health plans will not pay for these services.
- No claim should be submitted to Medicare, and Medicare will not pay if one is submitted.
- Your [Medigap policy](#), if you have one, will not pay anything for this service. Call your Medigap insurance company before you get the service if you have any questions.
- Many other insurance plans will not pay for the service either.
- Your doctor must tell you whether Medicare would pay for the service if you get it from another doctor who participates in Medicare.
- Your doctor must tell you if he or she has been excluded from the Medicare program.

It's important that you talk with someone in your [State Health Insurance Assistance Program](#) before signing a private contract (see page 75).



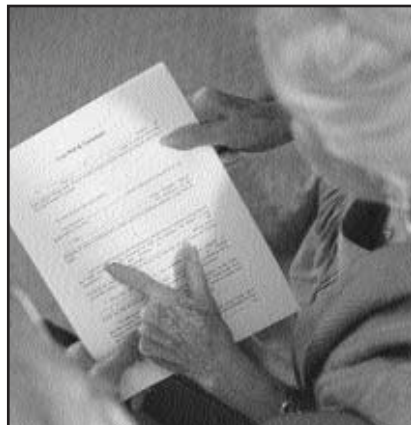
Q13: Can I pay for a service myself, if it is not covered by Medicare?

A: Yes. You can always choose to get services not covered by Medicare and pay for these services yourself. In this case, you do not have to sign a private contract.

Q14: Does Medicare pay for ambulance services?

A: Medicare pays for ambulance services when you must be taken to a hospital or skilled nursing facility and transportation in any other vehicle would endanger your health. Medicare pays for the ambulance mileage to the nearest hospital or skilled nursing facility that provides the services you need. Medicare does not pay for ambulance transportation to a doctor's office. For more information, get a free copy of *Medicare Coverage of Ambulance Services* (CMS Pub. No. 11021). Look on page 64 for details about how to get this booklet.

Introduction to Medicare Health Plans



Today's Medicare is about choice. Medicare is committed to offering you different ways to get your Medicare benefits and giving you the tools you need to make the choice that is best for you.

What are Medicare Health Plans?

The different options you have for getting your Medicare benefits are called Medicare health plans. One option is the Original Medicare Plan. Another option is a Medicare + Choice (pronounced "Medicare plus Choice") Plan. Private companies contract with the Medicare program to offer Medicare + Choice Plans. How you get your health care in the Medicare program depends on which health plan you choose. Depending on where you live, you may have more than one plan to choose from.

In 2003, Medicare offers the following types of Medicare health plans:

- The Original Medicare Plan (see page 23).
- Medicare + Choice Plans, including:
 - Medicare Managed Care Plans (like HMOs, see page 38), and
 - Medicare Private Fee-for-Service Plans (see page 39).

Remember, words in blue are defined on pages 65-67.



Making the Best Choice for You

How you get your Medicare health benefits affects many things like cost, doctor choice, benefits, convenience, and quality. They are all important, but some may be more important to you than others. You need to look at what plans are available in your area, what each plan offers, and make the best choice for you.

Your choice will affect:

Cost

What will your out-of-pocket costs be? More information about out-of-pocket costs starts on page 24.

Benefits

Do you need extra benefits and services, like prescription drugs, eye exams, hearing aids, or routine physical exams?

Doctor Choice

Can you see the doctor(s) you want to see? Do you need a referral to see a specialist?

Convenience

Where are the doctors' offices and what are their hours? Is there paperwork? Do you have to file claims yourself? Is there a telephone hotline for medical advice from a nurse or other medical staff?

Quality Data to Help You Choose

The Medicare program measures the quality of care that people like you get in Medicare health plans. This information is available to everyone. To compare the quality of care given by the Medicare health plans in your area, go to www.medicare.gov on the web. Select "Medicare Personal Plan Finder." Or, call 1-800-MEDICARE (1-800-633-4227) and ask for information about health plan quality. TTY users should call 1-877-486-2048.

Step-by-Step Help for Choosing the Right Plan for You

Choosing the right health coverage is an important – but sometimes difficult – decision. The “Medicare Personal Plan Finder” helps you narrow down your Medicare health plan choices and choose the plan that’s best for you. You can also get important information about special programs that might help you pay health care costs that Medicare doesn’t cover.

When you use the “Medicare Personal Plan Finder,” you will get a personalized summary page with general information to help you compare plans in your area. You can also get detailed information about all the plans available in your area, or just the ones you are most interested in.

You can get this personalized information two ways:

1. Visit www.medicare.gov on the web for fast results. Select “Medicare Personal Plan Finder.”
2. Call 1-800-MEDICARE (1-800-633-4227). For English, press “1” or for Spanish, press “2.” Select option “0.” A Customer Service Representative will help you. You will get your results in the mail within three weeks.

You will need to answer some simple questions, including:

- What parts of Medicare do you have (Part A and/or Part B)?
- What is your age?
- What is your general health?

If you want information about programs that may help with your health care costs, you will need to answer questions about your income and resources.

Any information you give is always kept private.

If you want to talk to someone about your health plan choices, call your [State Health Insurance Assistance Program](#) (see page 75).

Whether you get your Medicare health care coverage from the Original Medicare Plan or a Medicare + Choice Plan, you are still in the Medicare program.

The Original Medicare Plan and Medicare + Choice Plans are all part of the Medicare program. No matter how you choose to get your health care coverage:

You must have Medicare Part A and Part B to join a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan.

- You get at least all the Medicare Part A covered services listed on page 7.
- You get all the Medicare Part B covered services listed on pages 9-12 if you pay the monthly Part B **premium** (\$54 in 2002).
- The Medicare program can provide you information about the quality of the care given by Medicare health plans.
- The Medicare program pays for part of your health care.

What if I have other health insurance or coverage that isn't listed here?

Many people with Medicare also have health coverage in addition to Medicare. You may have or be able to get:

- Employer or union health coverage (see page 55),
- A Medigap (Medicare Supplement Insurance) policy (see pages 56-57),
- Veterans' benefits (see page 57),
- TRICARE for Life (for military retirees and their spouses and survivors, see page 58),
- Help from your state (see Medicare Savings Programs and Medicaid on pages 58-59),
- Prescription drug assistance programs (see page 59),
- Programs of All-inclusive Care for the Elderly (PACE) (see page 60), or
- Other insurance, like long-term care insurance (see page 60).



Section 3

Original Medicare Plan

What is the Original Medicare Plan?

The Original Medicare Plan is a “fee-for-service” plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 6). If you are happy getting your health care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a [Medicare Managed Care Plan](#) or [Medicare Private Fee-for-Service Plan](#).

How does the Original Medicare Plan work?

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- If you have Part A, you get all the Medicare Part A covered services listed on page 7.
- If you pay the monthly Part B [premium](#) (\$54 in 2002), you get all the Medicare Part B covered services listed on pages 9-12.
- You pay a set amount for your health care ([deductible](#)) before Medicare pays its part. Then, Medicare pays its share, and you pay your share ([coinsurance](#) or [copayment](#)).
- After you get a health care service, you get a Medicare Summary Notice in the mail (see pages 29-33). This notice is sent by companies that handle bills for Medicare. The notice lists the amount you may be billed.

**Remember,
words in
blue are
defined on
pages 65-67.**



Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on:

- Whether your doctor or supplier agrees to accept assignment (see pages 34-35).
- How often you need health care.
- What type of health care you need.
- Whether you get services or supplies not covered by Medicare.
- Whether you have Part A and Part B.

Note: In most cases, Medicare does not pay for health care you get while traveling outside of the United States (see Q3 on page 36).

The charts on the next few pages show what you pay in the Original Medicare Plan. For details about these covered services, see page 7 for Part A and pages 9-12 for Part B.

See pages 55-60 for information about help to cover the costs that the Original Medicare Plan does not cover.



Medicare Part A (Hospital Insurance) Helps Pay For:

Hospital Stays

What YOU Pay in 2002 in the Original Medicare Plan (see Note on page 26)

(For more information on coverage, see page 7.)

For each **benefit period** YOU pay:

- A total of \$812 for a hospital stay of 1-60 days.
- \$203 per day for days 61-90 of a hospital stay.
- \$406 per day for days 91-150 of a hospital stay. (See [Lifetime Reserve Days](#) on page 65.)
- All costs for each day beyond 150 days.

Skilled Nursing Facility (SNF) Care

Look on page 64 for details about how to get a free booklet for more information.

For each benefit period YOU pay:

- Nothing for the first 20 days.
- Up to \$101.50 per day for days 21-100.
- All costs beyond the 100th day in the benefit period.

If you have questions about SNF care and conditions of coverage, call your [Fiscal Intermediary](#) (see page 74).

Home Health Care

Look on page 64 for details about how to get a free booklet for more information.

YOU pay:

- Nothing for home health care services.
- 20% of the [Medicare-approved amount](#) for durable medical equipment.

If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 74).

Hospice Care

Look on page 64 for details about how to get a free booklet for more information.

YOU pay a [copayment](#) of up to \$5 for outpatient prescription drugs and 5% of the [Medicare-approved amount](#) for inpatient respite care (short-term care given to a hospice patient so that the usual caregiver can rest). The amount you pay for respite care can change each year. Room and board are generally not payable by Medicare except in certain cases. For example, room and board are not covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays.

If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see page 74).

Blood

YOU pay for the first 3 pints of blood, unless you or someone else donates blood to replace what you use.



Section 3: Original Medicare Plan

Medicare Part B (Medical Insurance) Helps Pay For:

Medical and Other Services

What YOU Pay in 2002 in the Original Medicare Plan (see Note below)

(For more information on coverage, see pages 9-12.)

Each year YOU pay:

- \$100 **deductible** (once per calendar year).
- 20% of **Medicare-approved amount** after the **deductible** (if the doctor or provider accepts “assignment,” see pages 34-35).
- 20% for all outpatient physical, occupational, and speech-language therapy services.
- 50% for outpatient mental health care. (See Q1 on page 36.)

Clinical Laboratory Services

YOU pay nothing for Medicare-approved services.

Home Health Care

Look on page 64 for details about how to get a free booklet for more information.

YOU pay:

- Nothing for Medicare-approved services.
- 20% of the **Medicare-approved amount** for durable medical equipment.

If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 74).

Outpatient Hospital Services

YOU pay a **coinsurance** or **copayment** amount, which may vary according to the service. Look on page 64 for details about how to get a free booklet for more information.

Blood

YOU pay for the first 3 pints of blood, then 20% of the **Medicare-approved amount** for additional pints of blood (after the **deductible**), unless you or someone else donates blood to replace what you use.

Note: New Medicare Part A and B amounts will be available after December 1, 2002. Actual amounts you must pay may be higher if the doctor or supplier does not accept assignment, **and you may have to pay the entire charge at the time of service.** Medicare will then send you its share of the charge (see page 34).

If you have general questions about Medicare Part B, call your **Medicare Carrier** (see page 76). If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (see page 76).



Section 3: Original Medicare Plan

Medicare Part B Covered Preventive Services

What YOU pay in the Original Medicare Plan

(For more information on coverage, see pages 10-11.)

Bone Mass Measurements

20% of the [Medicare-approved amount](#) (or a [copayment](#) amount) after the yearly Part B [deductible](#).

Colorectal Cancer Screening

Nothing for the fecal occult blood test. For all other tests, 20% of the [Medicare-approved amount](#) after the yearly Part B [deductible](#). For flexible sigmoidoscopy or colonoscopy, you pay 25% of the [Medicare-approved amount](#) if the test is done in a hospital outpatient department.

Diabetes Services and Supplies

20% of the [Medicare-approved amount](#) after the yearly Part B [deductible](#).

Glaucoma Screening

20% of the [Medicare-approved amount](#) after the yearly Part B [deductible](#).

Mammogram Screening

20% of the [Medicare-approved amount](#) with no Part B [deductible](#).

Pap Test and Pelvic Examination (includes a clinical breast exam)

Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the [Medicare-approved amount](#) (or a [copayment](#) amount) with no Part B [deductible](#).

Prostate Cancer Screening

Generally, 20% of the [Medicare-approved amount](#) for the digital rectal exam after the yearly Part B [deductible](#). No [coinsurance](#) and no Part B [deductible](#) for the PSA (Prostate Specific Antigen) Test.

Shots (vaccinations)

Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment (see pages 34-35). For Hepatitis B shots, 20% of the [Medicare-approved amount](#) (or a [copayment](#) amount) after the yearly Part B [deductible](#).



What is not paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan does not cover everything. Health care costs that are not covered include, but are not limited to:

- Acupuncture.
- **Deductibles**, **coinsurance**, or **copayments** when you get health care services (see the “What YOU Pay” part of the charts on pages 25-27).
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams.
- Long-term care, such as most nursing home care (see Q2 on page 36).
- Orthopedic shoes (with only a few exceptions).
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses (see page 12).
- Routine or yearly physical exams.
- Screening tests except those listed on pages 10-11.
- Shots (vaccinations) except those listed on page 11.
- Some diabetic supplies (like syringes or insulin unless it is used with an insulin pump).

See pages 55-60 for information about help to cover the costs that the Original Medicare Plan does not cover.



How are my bills paid in the Original Medicare Plan?

For Part A Services and some Part B Services:

The provider of the covered service sends a claim to your [Fiscal Intermediary](#) or your Regional Home Health Intermediary.

For Part B Services and Supplies:

The provider of the covered service or supply sends a claim to your [Medicare Carrier](#), or your Durable Medical Equipment Regional Carrier.

You get a Medicare Summary Notice (MSN). DO NOT send money to Medicare or to the provider until you get a bill. The MSN lists all the services or supplies that were billed to Medicare for that month. Check this notice to be sure you got all the services, medical supplies, or equipment that providers billed to Medicare. The MSN is not a bill.

If you have questions about your bills, see pages 74 and 76 for information about how to get important telephone numbers.

- Questions about the charges? Call the provider of the service or supply.
- Think a service you got should be covered? You can appeal (see page 49).
- Think the provider is being dishonest? Call the company that sent you the notice. Their telephone number is on the notice.

Note: You should not need to file any Medicare claims. Providers and Medicare enrolled suppliers are required by law to file Medicare claims for the covered services and supplies you get. If your doctor or supplier does not file the Medicare claim, call your Medicare Carrier.

How do I read the Medicare Summary Notice (MSN)?

Pages 30-33 have a sample MSN for Part B services, and information on how to read it. You could also get an MSN for Part A services and for durable medical equipment.



Medicare Summary Notice

1 June 16, 2003

NAME 4
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION 2

3 Your Medicare Number: 111-11-1111-A

If you have questions, write or call:

Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Phone number: (XXX) XXX-XXXX
1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

5
HELP STOP FRAUD: Protect your Medicare Number as you would a credit card number.

6 This is a summary of claims processed from 5/15/03 through 6/15/03.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 12345-84956-84556	8					14
Doctor name, Street Address, City, State ZIP Code	15	10	11	12	13	a
		\$55.00	\$44.35	\$0.00	\$44.35	b
03/07/03	1 Office/Outpatient Visit, ES (99214)					
7	9					

THIS IS NOT A BILL - Keep this notice for your records.

See page 32 for the rest of the Medicare Summary Notice.

See next page for an explanation of the numbered items 1-12.

See page 33 for an explanation of the numbered items 13-15.



Explanation of numbered items on Medicare Summary Notice (MSN)

1. The **Date** the MSN was sent.
2. The **Customer Service Information** box. Write or call using the information in this box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.
3. Your **Medicare Number**. It should match the number on your Medicare card.
4. Your **Name and Address**. If these are incorrect on your MSN, please contact both the company shown in the customer service information section and the Social Security Administration immediately.
5. Read the **Help Stop Fraud** message for information on ways to protect yourself and Medicare against fraud and abuse.
6. **Part B Medical Insurance - Assigned Claims/Unassigned Claims**. This line describes the category of services received. It tells you if it is a Medicare Part A or B service or durable medical equipment. See the back of your MSN for an explanation of Medicare assignment.
7. **Dates of Service**. This shows when your doctor or supplier provided the service(s) listed. You may use these dates to compare with the dates shown on your doctor or supplier bill.
8. Each claim is assigned a **Claim Number**, which you may be asked to provide when calling regarding your MSN.
9. **Services Provided** is a brief description of the service or supply, the number of services and the service code.
10. **Amount Charged** is the charge submitted to Medicare by the provider of service(s).
11. **Medicare Approved** is the amount Medicare approved for the service(s) you received.
12. **Medicare Paid Provider**. In most situations, Medicare pays 80 percent of the approved amount after subtracting any unmet portion of the yearly deductible. For unassigned service(s), this column is titled Medicare Paid You.



Medicare Summary Notice (continued)

Notes Section: 16

- a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.
- b This approved amount has been applied toward your deductible.

Deductible Information: 17

You have now met \$44.35 of your \$100 Part B deductible for 2003.

General Information: 18

Please notify us if your address has changed or is incorrect as shown on this notice.

Appeals Information - Part B 19

If you disagree with any claims decision on this notice, you can request an appeal by December 16, 2003.

Follow the instructions below:

- 1) Circle the item(s) you disagree with and explain why you disagree.
- 2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.
- 3) Sign here _____ Phone Number (____) _____

See next page for an explanation of the numbered items 13-19.



- 13. You May Be Billed.** This is the total amount the provider is allowed to bill you. It combines the deductibles, the coinsurance and any non-covered charges. If you have other insurance that supplements the Original Medicare Plan, it may pay all or part of this amount. There may be other laws in your state that limit doctors' charges.
- 14. See Notes Section.** If a letter appears in this column, refer to the Notes Section. Please see item 16.
- 15. Provider's Name and Address.** More than one name may be shown. If you were treated by a clinic or group medical practice, the clinic or group name will be shown, followed by the name of the doctor who performed the service. If the service was ordered or referred by another doctor, the referring doctor's name may also be listed. The address shown is the billing address which may be different from where you received the service(s).
- 16.** The **Notes Section** gives more detailed information about your claim.
- 17.** The **Deductible Information** section shows how much of your yearly deductible has been met.
- 18.** The **General Information** section provides important Medicare news and information.
- 19.** The **Appeals Information** section provides information such as how and when to request an appeal. See the back of your MSN for more information and how to get help with appeal requests.



What is “assignment” in the Original Medicare Plan and why is it important?

Assignment is an agreement between Medicare, and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors, providers, and suppliers who agree to accept assignment accept the [Medicare-approved amount](#) as payment in full for Part B services and supplies. You pay the [coinsurance](#) and [deductible](#) amounts. In some cases (such as for Medicare-covered ambulance services), your health care providers and suppliers must accept assignment.

If assignment is not accepted, charges are often higher. This means you may pay more. In addition, you may have to pay the entire charge at the time of service. Doctors and suppliers must submit your claim to Medicare. Medicare will then send you its share of the charge.

For most services, there is a limit on the amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and other health care providers who don't accept assignment is called the [limiting charge](#). The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.



Important Information about Assignment, Prescription Drugs, and Supplies

If you get Medicare-covered prescription drugs or supplies, ask if the pharmacy or supplier is enrolled in the Medicare program. If not, Medicare will not pay.

All enrolled pharmacies must accept assignment for Medicare-covered prescription drugs or biologicals. If you have paid your \$100 yearly Part B deductible, you only have to pay your 20% coinsurance when you get these items.

If you get Medicare-covered supplies, ask if the pharmacy or supplier is enrolled in Medicare. If so, they must accept assignment. If you have paid your \$100 yearly Part B deductible, you only have to pay your 20% coinsurance at the time you get your supplies.

New: All enrolled pharmacies and suppliers for glucose test strips must submit the claim. You cannot send in the claim yourself.

For more information about assignment, get a free copy of *Does Your Doctor or Supplier Accept Assignment?* (CMS Pub. No. 10134). Look on page 64 for details about how to get this booklet.



Common Questions and Answers

Q1: Does the Original Medicare Plan cover mental health care?

A: Yes. If you are in the Original Medicare Plan, Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, clinical social worker, and lab tests. For outpatient mental health services, Medicare pays 50 percent of the costs. You pay the other 50 percent. For more information about Medicare coverage for mental health care, get a free copy of *Medicare and Your Mental Health Benefits* (CMS Pub. No. 10184). Look on page 64 for details about how to get this booklet.

Q2: Does Medicare pay for care in a nursing home?

A: Usually, no. Most nursing home care is custodial care (help with activities of daily living like bathing, dressing, using the bathroom, and eating). This care is not covered by Medicare. Medicare Part A only covers skilled care given in a certified skilled nursing facility. You must meet certain conditions for Medicare to pay for these types of care when you get out of the hospital. For more information about Medicare skilled nursing care, get a free copy of *Medicare Coverage of Skilled Nursing Facility Care* (CMS Pub. No. 10153). Look on page 64 for details about how to get this booklet.

Q3: Does the Original Medicare Plan cover me when I travel outside of the United States?

A: Usually, no. The Original Medicare Plan does not cover health care when you travel outside the United States, except for some emergency situations in Mexico and Canada. Some [Medigap policies](#) (see pages 56-57) do cover care outside the United States. Check your insurance coverage before you travel outside the country.

Medicare + Choice Plans

What are Medicare + Choice Plans?

You can get your coverage through the Original Medicare Plan or Medicare + Choice Plans. Congress created the Medicare + Choice program to provide you with more choices and, sometimes, extra benefits, by letting private companies offer you your Medicare benefits. Your choices may include:

- Medicare Managed Care Plans (like HMOs), and
- Medicare Private Fee-for-Service Plans.

These plans are available in many areas of the country. Information about the Medicare health plans available in your area starts on page 77. You can also look at www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the most up-to-date and detailed health plan information.

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice Plan manages the Medicare coverage for its members. If Medicare Managed Care Plans or Medicare Private Fee-for-Service Plans are available in your area, you can join one and get your Medicare-covered benefits through the plan. By joining one of these Medicare + Choice Plans, you can often get extra benefits, like coverage for prescription drugs or additional days in the hospital. The plan may have special rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

If you join a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan:

- You are still in the Medicare program.
- You still get all your regular Medicare-covered services (see pages 7-12).
- You may be able to get extra benefits like prescription drugs or additional days in the hospital.
- You still have Medicare rights and protections (see page 49).

Remember, you must have Medicare Part A and Part B to join a Medicare + Choice Plan. If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan.

**Remember,
words in
blue are
defined on
pages 65-67.**



Why do some people join Medicare Managed Care Plans?

You may be able to get extra benefits like coverage for prescription drugs, and more preventive and wellness services. You may get better-coordinated care, and have access to disease management programs. There may be less paperwork than under fee-for-service Medicare. You should contact any plan you are thinking of joining to find out about its benefits and rules.

How does a Medicare Managed Care Plan work?

- These are the general rules for how Medicare Managed Care Plans work. For some of these rules, plans may differ slightly, so it is important to call your plan.
- In most Medicare Managed Care Plans, there are doctors and hospitals that join the plan (called the plan's "network"). You are likely to need to get most of your care and services from the plan's network. Call the plan to see which doctors and hospitals are in the plan.
- When you join a plan, you will be asked to choose a [primary care doctor](#). If you want to change your primary care doctor, you can ask your plan for the names of other plan doctors in your area.
- Doctors can join or leave Medicare Managed Care Plans at any time. If your doctor should leave your plan, you will be notified in advance and given the chance to pick a new doctor.
- Special rules might apply in emergencies or for urgently needed care (see Q9 and Q10 on pages 47-48).
- Some Medicare Managed Care Plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not a part of the plan ("out-of-network"), but may cost extra.
- If you get health care outside the service area of the plan, you may pay more. The service area is where the plan accepts members and where to get services from the plan.
- You might need a referral to see a specialist (like a cardiologist). A referral is an OK from your primary care doctor for you to see a specialist or get certain services.
- There are special rules for certain services. For example, if you are a woman, you can go once a year, without a special referral, to a specialist in the network for routine and preventive women's care services. If the specialist you need isn't available, the plan will arrange for care outside the network.
- At the end of each year, Medicare Managed Care Plans may leave the Medicare program. However, new plans may also become available.

How does a Medicare Private Fee-for-Service Plan work?

- The Medicare Private Fee-for-Service Plan pays the doctor or hospital for the care you get. You may have to pay a premium and other costs (like a copayment) that are different than under the Original Medicare Plan.
- You can go to any doctor or hospital that is willing to give you care and accepts the terms of your plan's payment. You should check how much your out-of-pocket costs will be before joining a Medicare Private Fee-for-Service Plan.
- The private company provides health care coverage to people with Medicare who join this plan. Before you get care, tell the doctor or hospital that you have a Medicare Private Fee-for-Service Plan. If the doctor or hospital agrees to treat you, you must pay a fee (like a copayment) for the services you get. The private company will pay the rest of the fee.
- The private company may have a “pre-notification” requirement. For example, it may require that you tell the plan of any planned inpatient hospital stays.
- If the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services, you may pay more. If this is allowed, there may be a limit to what they can charge, and how much you must pay.
- At the end of each year, the companies offering Medicare Private Fee-for-Service Plans can decide to join, stay with, or leave Medicare.

Your costs in a Medicare + Choice Plan

What you pay out-of-pocket depends on:

- Whether the plan charges a monthly **premium** in addition to your monthly Part B premium (\$54 in 2002).
- How much you pay for each visit or service (like a copayment).
- The type of health care you need and how often you get it.
- The types of extra benefits you need, and whether the plan covers them.
- Whether you follow plan rules. If you do not, you may have to pay the full cost for your care.

Note: To get summaries of your out-of-pocket costs in various plans, look at www.medicare.gov on the web. Select “Medicare Personal Plan Finder.”

A New Way to Save on Your Medicare Part B Premium

Starting January 1, 2003, Medicare + Choice Plans may offer an additional benefit by reducing the amount you pay for your Medicare Part B premium. If you join a plan that offers this benefit, it may save you money. You should read the plan materials carefully before joining to see if the Medicare + Choice Plan you are interested in will offer this benefit.

If the Medicare + Choice Plan chooses to offer this benefit, it must offer it to every person with Medicare who joins the plan. The Medicare + Choice Plan decides each year if they are going to reduce part or all of your Medicare Part B premium.

Important: Even though your Medicare Part B premium would be reduced, you would still get all Medicare Part A and Part B covered services. Reducing your Medicare Part B premium costs would not affect the services and care you get from the Medicare + Choice Plan.

Joining a Medicare + Choice Plan

Who can join a Medicare + Choice Plan?

If you have Medicare, you can join a Medicare + Choice Plan if:

- You have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) and continue to pay the monthly Medicare Part B premium (\$54 in 2002). If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan.
- You live in the service area of the plan. The service area is where you must live for the plan to accept you as its member. In the case of a Medicare Managed Care Plan, it's also usually where you get services from the plan. The plan can give you more information about its service areas.
- You do not have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Special Rules for People with End-Stage Renal Disease:

If you have End-Stage Renal Disease (ESRD), you usually cannot join a [Medicare + Choice Plan](#). However, if you are already in a plan, you can stay in the plan you are in or join another plan offered by the same company in the same state. If you've had a successful kidney transplant, you may be able to join a plan.

Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans.

If you have ESRD and are in a Medicare + Choice Plan, and the plan leaves Medicare or no longer provides coverage in your area, you can join another Medicare + Choice Plan if one is available in your area.

Joining a Medicare + Choice Plan (continued)

When can I join one of these plans?

Generally, you can join a Medicare + Choice Plan at any time. However, Medicare + Choice Plans must accept new members from November 15 through December 31 of each year. If you join a Medicare + Choice Plan during this time, your coverage begins on January 1 of the next year.

Note: Some Medicare + Choice Plans limit the number of members in their plans. These plans may not accept new members when they reach their limit. A plan can tell you if it is signing up new members. Also, if you are in an institution (like a nursing home), check with the plan to see if you may be able to join at other times.

How do I join a Medicare + Choice Plan?

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or
2. Get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative. The plan representative can help you fill out the form.

You will get a letter from the plan telling you when your coverage begins.

Caution: You can't join more than one Medicare + Choice Plan at the same time. If you try to join more than one Medicare + Choice Plan with the same starting dates, you may be returned to the Original Medicare Plan.

Joining a Medicare + Choice Plan (continued)

Can I keep my Medigap (Medicare Supplement Insurance) policy if I join a Medicare + Choice Plan?

Yes, you can keep it. However, it may cost you a lot and you may get little benefit from it while you are in a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan.

If you drop your [Medigap policy](#), you may not be able to get it back, except in certain situations. If you join a Medicare + Choice Plan when you first become eligible for Medicare at age 65, or if this is the first time you've enrolled in a Medicare + Choice Plan, you may have special Medigap protections that give you a right to buy a [Medigap policy](#). For more information on Medigap policies and protections, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). Look on page 64 for details about how to get this booklet.

How can I tell if I am in a Medicare + Choice Plan?

If you join a Medicare + Choice Plan, you should get a membership card with the name of the plan on it. If you are not sure if you are in a Medicare + Choice Plan, you can call the telephone number listed on your membership card. You can also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772. Ask the Customer Service Representative to check if you are in a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan.

Leaving a Medicare + Choice Plan

When can I leave a Medicare + Choice Plan?

You may leave your plan at any time for any reason.

How do I leave my Medicare + Choice Plan to join a new Medicare + Choice Plan?

You can leave your Medicare + Choice Plan to join a new Medicare + Choice Plan by enrolling in the new plan. You do **not** need to tell your old plan or send them anything. You will be disenrolled automatically from your old plan when your new plan coverage begins. You should get a letter from your new plan telling you when your coverage starts.

How do I leave my Medicare + Choice Plan and return to the Original Medicare Plan?

You can leave your Medicare + Choice Plan and return to the Original Medicare Plan in one of three ways:

1. Write or call your plan,
2. Visit, call, or write the Social Security Administration, or
3. Call 1-800-MEDICARE (1-800-633-4227).

Tell them that you want to leave your Medicare + Choice Plan. The plan should send you a letter with the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

If you get benefits from the Railroad Retirement Board, you should contact your local RRB office or call 1-800-808-0772 if you want to leave your Medicare + Choice Plan.

Note: If you want to buy a [Medigap policy](#), you need to end your coverage with your Medicare + Choice Plan in one of the three ways listed above. Simply signing up for the Medigap plan will **not** end your Medicare + Choice Plan coverage.

What if I move out of the plan's service area?

You will need to call the health plan to see if you can stay in the plan if you move out of the plan's service area. If you must leave the Plan, follow the instructions above for leaving a Medicare + Choice Plan. You can choose to join another Medicare + Choice Plan, if one is available in your new area and they are accepting new members, or, you can choose the Original Medicare Plan.

Common Questions and Answers

Q1: How do I find out if my doctor or hospital belongs to a Medicare Managed Care Plan?

A: If you want to keep seeing your doctor when you join a Medicare Managed Care plan, call and ask if he or she is in the Medicare Managed Care Plan and can continue to see you if you joined the plan. You can also get a list from your plan of doctors and hospitals that belong to the plan. Doctors can join and leave Medicare Managed Care Plans at any time.

Q2: Can I join a Medicare + Choice Plan if I have employer or union coverage?

A: If you join a Medicare + Choice Plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare + Choice Plan coverage. Talk to your employer or union benefits administrator about the rules that apply. Remember, if you drop your employer or union coverage, you may not be able to get it back.

Q3: Do Medicare + Choice Plans cover me when I travel outside the United States?

A: Some Medicare + Choice Plans cover you when you travel outside of the United States. Check with your plan before you leave the country.

Q4: Is mental health care covered in a Medicare + Choice Plan?

A: If you are in a Medicare + Choice Plan, read your plan materials or call the plan to learn about its coverage of mental health care. You must get at least the same coverage as provided by Medicare Part A and Part B of the Original Medicare Plan.

Q5: Who decides where Medicare + Choice Plans will be available?

A: Medicare Managed Care Plans and Medicare Private Fee-for-Service Plans are offered by private companies. A company can decide, with Medicare's approval, that a plan will be available to everyone with Medicare in a state, or be open only in certain counties or parts of counties. A company may also choose to offer more than one plan in an area, with different benefits and costs. Each year, companies offering Medicare + Choice Plans can decide to stay in or leave Medicare.

Companies may decide to offer plans in your area in the future. For the most up-to-date information about Medicare + Choice Plans in your area:

- Look at www.medicare.gov on the web. Select “Medicare Personal Plan Finder.”
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Q6: How long do private companies contract with Medicare to offer Medicare + Choice Plans?

A: When a private company decides to offer a Medicare + Choice Plan, it agrees to stay in the Medicare program for the entire year, January 1 through December 31. Each year, they make a business decision to stay in or leave the Medicare program for the following year. Costs and extra benefits can also change each year.

Q7: What can I do if my Medicare + Choice Plan doesn't stay in the Medicare program?

A: If your Medicare + Choice Plan leaves the Medicare program, you will be sent a final notification letter. The letter will tell you if there are other Medicare + Choice Plans in your area that you can join. You can always choose the Original Medicare Plan. You will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare + Choice Plan. You may have the right to buy a [Medigap policy](#) (see pages 56-57). In this case, you should learn as much as you can about your choices before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare-covered services.

Q8: What can I do if my Medicare + Choice Plan reduces its service area and there are no other plans available in my area when I lose my coverage?

A: If your Medicare + Choice Plan reduces its service area and there are no other Medicare + Choice Plans in your area when you lose coverage, you may be able to keep your coverage. Ask your plan. In order to keep your coverage, you must agree to get all your services (except for emergencies and urgently needed care) in the reduced service area. If your plan does not offer this option, you will automatically return to the Original Medicare Plan on January 1. In this case, you may have the right to buy a [Medigap policy](#) (see pages 56-57).

Q9: What is a “medical emergency”?

How do I get emergency care in a Medicare + Choice Plan?

A: A medical emergency is when you believe that your health is in serious danger — when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse.

All Medicare + Choice Plans must allow you to get emergency care whenever you need it from any provider in the United States. Your plan must pay for emergency care and you may have to pay a portion of the cost. If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency care, you have the right to [appeal](#) (see Q11 on page 48).

You do not need to get permission from your Medicare + Choice Plan or [primary care doctor](#) first.

Q10: What is “urgently needed care”?

How do I get urgent care in a Medicare + Choice Plan?

A: Urgently needed care is care you need for a sudden illness or injury that is not a medical emergency.

In a [Medicare Managed Care Plan](#), you get urgently needed care from your [primary care doctor](#). However, if you are in the United States but out of the plan’s service area and cannot wait until you return home, your plan must pay for urgently needed care (you may have to pay a portion of the cost). If it does not, you have the right to [appeal](#) (see Q11 below).

In a [Medicare Private Fee-for-Service Plan](#), you can get urgently needed care from any doctor who accepts the terms of the plan’s payment.

Q11: Can I [appeal](#) my Medicare + Choice Plan’s payment decisions?

A: Yes. You have the right to a fair, efficient, and timely process for resolving issues related to your health plan’s payment of a service or product. This process is called an appeal. Your plan must tell you in writing how to appeal a plan decision. You have the right to file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. After you file an appeal, the plan will review its decision. If waiting for a decision will harm your health, the plan must answer you within 72 hours. If your plan does not decide in your favor, it will send your appeal to an independent review organization. See your plan’s membership materials or call your plan for details about your appeal rights and how to file an appeal. You have a right to ask your plan for a copy of your file. It contains your medical and other information about your appeal.

For more information about your appeal rights, get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112). Look on page 64 for details about how to get this booklet.



Section 5

Your Medicare Rights



Your Medicare Rights

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. No matter how you get your Medicare health care, you always have the right to [appeal](#). Some of the reasons you may appeal are when:

- You don't agree with the amount that is paid.
- A service or item isn't covered and you think it should be covered.
- A service or item is stopped before you think it should be.

The instructions for filing an appeal are either on the notice that explains what Medicare pays (see page 29) or in your health plan materials, depending on how you get your Medicare health care. If you decide to file an appeal, ask your doctor or provider for any information that may help your case. You can also call your [State Health Insurance Assistance Program](#) for help filing an appeal (see page 75).

If you are in the Original Medicare Plan, you are protected from unexpected bills. A doctor or supplier might give you a notice that says Medicare probably (or certainly) will not pay for a service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare does not pay for it. This is called an Advance Beneficiary Notice. Advance Beneficiary Notices are used in the Original Medicare Plan, but not in Medicare + Choice Plans.

If you aren't sure if Medicare was billed for the services that you got, write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from your doctor, hospital, or any other health supplier. You should get it within 30 days. Also, you can check your Medicare Summary Notice to see if the service was billed to Medicare.

If you are in a Medicare Private Fee-for-Service Plan, call your plan to find out if a service or item will be covered. The plan must tell you if you ask.



Section 5: Your Medicare Rights

In addition, you have certain rights to:

You may have additional rights if you are in the hospital or a skilled nursing facility, or if your home health care ends.

- Information
- Get emergency services
- See Doctors; Specialists, including women's health specialists; and go to Medicare-certified hospitals
- Participate in treatment decisions
- Know your treatment choices
- Culturally competent services (for example, getting materials that are translated into a language you can understand)
- File complaints
- Nondiscrimination
- Privacy of personal information
- Privacy of health information

For more detailed information about your rights and protections, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112). Look on page 64 for details about how to get this booklet.

New Notice of Medicare Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out (“disclose”) your personal medical information held by Medicare.

Medicare **must** use and give out your personal medical information to provide information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.



New Notice of Medicare Privacy Practices (continued)

Medicare **has the right** to use and give out your personal medical information to pay for your health care and to operate the Medicare program. For example:

- Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, or to resolve any complaints you have.

Medicare **may** use or give out your personal medical information for the following purposes under limited circumstances:

- To State and other federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist federal/State Medicaid programs),
- For public health activities (such as reporting disease outbreaks),
- For government healthcare oversight activities (such as fraud and abuse investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and imminent threat to health or safety,
- To contact you about new or changed benefits under Medicare, and
- To create a collection of information that can no longer be traced back to you.

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission.



New Notice of Medicare Privacy Practices (continued)

By law, you have the right to:

- See and get a copy of your personal medical information held by Medicare.
- Have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from Medicare. The listing will not cover your personal medical information that was given to you or your personal representative, that was given out to pay for your healthcare or for Medicare operations, or that was given out for law enforcement purposes.
- Ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. box instead of your home address).
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare program. Please note that Medicare may not be able to agree to your request.
- Get a separate paper copy of this notice.

If you believe Medicare has violated your privacy rights set out in this notice, you may file a complaint with Medicare at the following address:

Privacy Complaints
P.O. Box 8050
U. S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Filing a complaint will not affect your benefits under Medicare. You also may file a complaint with the Secretary of the Department of Health and Human Services.

For more information on filing a complaint or exercising your rights set out in this notice, look at www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Ask to speak to a Customer Service Representative about Medicare's privacy notice.



New Notice of Medicare Privacy Practices (continued)

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes, you will get a new notice by mail within 60 days of the change.

The privacy practices listed on pages 50-52 will be effective April 14, 2003.

You Are Protected From Discrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, or religion under certain conditions. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your state (see page 73) or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also look at www.hhs.gov/ocr on the web for more information.

Let People Know Your Wishes About The Health Care You Want Even If You Cannot Tell Them Yourself

As people live longer, the chance that they may not be able to make their own health care decisions increases. Alzheimer's and other diseases affect the ability to make health care decisions. To let people know what kind of treatment you want if you lose the ability to make your own health care decisions in the future, you need to fill out a "health care advance directive" (also called a living will). An "advance directive" is a written document in which you give directions about who you want to speak for you and what kind of health care you want or don't want if you cannot speak for yourself. For more information, call your [State Health Insurance Assistance Program](#) (see page 75).

You Can Help Protect Yourself and Medicare from Fraud

Most doctors and health care providers who work with Medicare are honest. There are a few who are not honest. Medicare is working very hard with other government agencies to protect the Medicare program.

Medicare fraud happens when Medicare is billed for services you never got. Medicare fraud takes a lot of money every year from the Medicare program. You pay for it with higher premiums. A fraud scheme can be carried out by individuals, companies, or groups of individuals.



You Can Help Protect Yourself and Medicare from Fraud (continued)

Use the 3 Step approach if you suspect fraud:

1. Call your health care provider.
2. Call your Medicare Carrier or Fiscal Intermediary.
3. Call the Inspector General's hotline (1-800-447-8477).

When you get health care in the Original Medicare Plan, you get a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. You should check the notice for mistakes. Make sure that Medicare wasn't charged for any services or supplies that you did not get. If you see a charge on your bill that may be wrong, call the health care provider and ask about it. The bill may be correct, and the person you speak to may help you to better understand the services or supplies you got. Or, you may have discovered an error in billing which needs to be corrected. If you are not satisfied after speaking with your provider, call the [Medicare Carrier](#) or [Fiscal Intermediary](#). Their telephone number is printed on top of the notice.

You can also call the Inspector General's hotline to report Medicare fraud. Medicare will not use your name if you ask that it not be used.

Fighting fraud can pay. You may get a reward of up to \$1,000 if:

- You report Medicare fraud,
AND
- Your report leads directly to the recovery of at least \$100 of Medicare money,
AND
- The fraud you report is not already being investigated.

If you want to know more about this program, call your Medicare Carrier (see page 76) or Fiscal Intermediary (see page 74).

Other Insurance and Ways to Pay Health Care Costs



Do you know what health care insurance you have and what it helps pay for? Now is a good time to review your coverage. Medicare may not be the only health care coverage you have or can get. You might be able to get more health care benefits than you get with Medicare alone or help to lower your out-of-pocket costs by having or buying more health care coverage. The coverage you have will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you.

For more information about how these kinds of insurance work with Medicare, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 64 for details about how to get this booklet.

1.

Employer or Union Health Coverage

Call the benefits administrator at your or your spouse's current or former employer or union. Ask if you have or can get health care coverage based on your or your spouse's past or current employment.

When you have retiree coverage from an employer or union, they manage this coverage. They may change the benefits or **premiums**, and may also cancel the coverage if they choose.

Caution: If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your employer's or union's benefits administrator.

2.

Medigap (Medicare Supplement Insurance) Policies

If you live in Massachusetts, Minnesota, or Wisconsin, different standardized plans are sold in your state. See page 75 for important contact information.

A [Medigap policy](#) is a health insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Medigap policies must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies so you can compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high [deductible](#) option. In addition, any standardized policy may be sold as a “Medicare SELECT” policy. Medicare SELECT policies usually cost less because you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, you may use any doctor or hospital.

For more information about Medigap policies, costs and choices, call 1-800-MEDICARE (1-800-633-4227) and speak with a Customer Service Representative or call your State Health Insurance Assistance Program (see page 75).

Do I need to buy a Medigap policy?

You may want to buy a Medigap policy because the Original Medicare Plan does not pay for all of your health care. There are “gaps” or costs you must pay in the Original Medicare Plan. Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a [Medicare + Choice Plan](#).

You do not need to buy a Medigap policy if you are in a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan. In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans. If you have [Medicaid](#), it is illegal for an insurance company to sell you a Medigap policy except in certain situations.

2.

Medigap (Medicare Supplement Insurance) Policies (continued)

When is the best time to buy a Medigap policy?

The best time to buy a [Medigap policy](#) is during your Medigap open enrollment period. Your Medigap open enrollment period lasts for 6 months. It starts on the first day of the month in which you are both age 65 or older and are enrolled in Medicare Part B. Once the 6-month Medigap open enrollment period starts, it cannot be changed.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or charge you more for a policy because of your past or present health problems. They must also shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have.

Important: If you don't buy a Medigap policy during your open enrollment period, you may not be able to buy the one you want later, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back.

Note: If you are age 65 or older, and you or your spouse are working, and you have health coverage through an employer or union based on your or your spouse's current or active employment, you may want to wait to enroll in Medicare Part B and delay your Medigap open enrollment period.

For information about buying a Medigap policy, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). Look on page 64 for details about how to get this booklet.

3.

Veterans' Benefits

If you are a Veteran, call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about Veterans' benefits and services available in your area.

4.

Military Retiree Benefits

TRICARE for Life (TFL) provides expanded medical coverage for: Medicare-eligible uniformed services retirees, including retired National Guard members and reservists; Medicare-eligible family members and widow/widowers; and certain former spouses if they were eligible for TRICARE before age 65. You must have Medicare Part A and Part B to be eligible for TFL.

If eligible, you get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. If you use a Medicare provider, Medicare will be the first payer for all Medicare-covered services, and TFL will be the second payer. TFL will pay all Medicare [copayments](#) and [deductibles](#) and cover most of the costs of certain care not covered by Medicare.

For more information about TFL, call 1-888-DOD-LIFE (1-888-363-5433) or look at www.TRICARE.osd.mil on the web. Call 1-800-538-9552 for other military retiree eligibility and benefit questions.

5.

Medicare Savings Programs (Help From Your State)

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited income and resources that pay some or all of Medicare's [premiums](#). Some programs may also pay Medicare [deductibles](#) and [coinsurance](#).

You can apply for these programs if:

- You have Medicare Part A. (If you pay for Medicare Part A but don't think you can afford to, there is a program that may pay the Medicare Part A premium for you.)

and

- You are an individual with resources of \$4,000 or less, or are a couple with resources of \$6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds.

and

(continued on next page)

Medicare Savings Programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

5.

Medicare Savings Programs (continued)

- You are an individual with a monthly income of less than \$906,* or are a couple with a monthly income of less than \$1,214.*

Call your State Medical Assistance Office (see page 75) and ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

*Income limits will change slightly in 2003. If you live in Alaska or Hawaii, income limits are slightly higher.

Note: Individual states may have more generous income and/or resource requirements.

6.

Medicaid

If your income and resources are even more limited than those described above, you may qualify for [Medicaid](#). Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. Medicaid is a joint federal and state program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for things like nursing home care and outpatient prescription drugs that are not covered by Medicare. For more information about Medicaid, call your State Medical Assistance Office (see page 75).

7.

Prescription Drug Assistance Programs

There are programs that may offer you discounts or free medication. For more information, look at www.medicare.gov on the web. Select "Prescription Drug Assistance Programs." If you don't have a computer, your local senior center or library may be able to help you get this information. Or, call 1-800-MEDICARE (1-800-633-4227) and ask for information about these programs.

8.

The PACE Program (Programs of All-inclusive Care for the Elderly)

PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid.

To find out if you are eligible, to find if there is a PACE site near you, or for more information, call your State Medical Assistance Office (see page 75). You can also look at www.medicare.gov/Nursing/Alternatives/PACE.asp on the web for PACE locations and telephone numbers.

9.

Long-Term Care Insurance

Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare does not pay for long-term care.

It is very important to think about long-term care before you may need care or before a crisis occurs. You will have more control over your decisions. For more information about the types of long-term care, get a free copy of *Choosing Long-Term Care: A Guide for People with Medicare* (CMS Pub. No. 02223). Look on page 64 for details about how to get this booklet.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see page 75) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

State Children's Health Insurance Program (SCHIP)

Free or low-cost health insurance is available now in your state for uninsured children under age 19. State Children's Health Insurance Programs help reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. Information on your State's program is available through Insure Kids Now at 1-877-KIDS-NOW (1-877-543-7669). You can also look at www.insurekidsnow.gov on the web for more information.

Need answers and information now? Visit our website, www.medicare.gov

How do I replace my Medicare card? I need a copy of a Medicare publication – What’s the fastest way to get it? How do I keep up with what’s new in Medicare?

Answers to these questions and more are as close as a computer. Go to Medicare’s website for quick answers to your questions. The site is updated regularly, so visit often.



★ Publications

Read all of the Medicare publications on your computer or print out a copy to use now.

★ Compare Medicare Health Plans and Medigap Policies

Find the Medicare health plan that’s right for you. Compare information about costs, benefits, and the quality of health plan care. To shop for health plans, use the “Medicare Personal Plan Finder” to find the plans that best meet your needs.

★ Compare Nursing Homes

Trying to find a nursing home? Check out “Nursing Home Compare” for details on nursing homes in your area, including state inspection results and nursing staff information, and information about nursing home quality.

★ Learn about your Benefits

Select “Your Medicare Coverage” to see what is covered, when it’s covered, and how much you pay in the Original Medicare Plan.

★ Answers to your Questions

Find basic information on Medicare, including coverage, eligibility, enrollment, and answers to frequently-asked questions. Let www.medicare.gov be your first stop for the answers you need now.

★ Look for a Physician or Supplier

Select the “Participating Physician Directory” or “Supplier Directory” for a list of physicians or suppliers who participate in Medicare. These directories include names, addresses, and more.

★ Need help paying for Prescription Drugs?

Select “Prescription Drug Assistance Programs” for programs that may offer you discounts or free medication.

★ And more...

Medicare’s website helps you find the answers you need. You can search for what Medicare covers, health information, telephone numbers for helpful contacts, and more. Some information is available in Spanish and Chinese.



Call 1-800-MEDICARE (1-800-633-4227).

**To get answers and information,
24 hours a day, including weekends.**

When you call, you will hear:

Thank you for calling 1-800-MEDICARE.

We offer service in English and Spanish.

• For **English**, press (1). • Para **Español**, oprima dos (2).

Please choose from the following six **Main Menu** options:

To sign up for
Medicare, change
your address, or
replace your
Medicare card...

Press **1** now

For information
on Medicaid
programs that may
help those with
low incomes pay
prescription drugs
and medical bills...

Press **2** now

To find out how
your doctor or
hospital bill is
paid...

Press **3** now

Tip: You can call the Social Security Administration at 1-800-772-1213 to get the information for option 1.



Call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.



To order Medicare publications...

Press **4** now

For answers to frequently asked questions, including information about Medicare health plan choices...

Press **5** now

To speak to a Customer Service Representative, for general Medicare information or for information about Medicare health plan choices in your area...

Press **0** now

You can also visit www.medicare.gov on the web for quick answers to your questions.



Free Booklets About Medicare and Related Topics

Medicare tries to give you information to help you make good health care decisions. You can look at or order free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects.

How do I get these booklets?

1. Look at www.medicare.gov on the web and select “Publications.” You can read, print, or order these booklets. This is the fastest way to get a copy.
2. Call 1-800-MEDICARE (1-800-633-4227), and select option “4” to order a free copy of the booklet you want. Have the publication number ready when you call. TTY users should call 1-877-486-2048. You will get your copy within three weeks.
3. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select “Mailing List” at the bottom of the page. Then, select the topic “Publications,” type your e-mail address in the box at the bottom, and select “Subscribe.”

Many booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Some booklets are also available in Chinese.

Look at www.medicare.gov on the web for a list of available Medicare publications.

Note: Some booklets may not be available in print, but all of the most up-to-date versions will be available at www.medicare.gov on the web.

Words To Know

Section 8

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, you would file an appeal if Medicare doesn't pay or doesn't pay enough for a service you got, you don't get, or an item or service you think you should get. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital or skilled care (in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5 or \$10 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Critical Access Hospital - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Deductible - The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Fiscal Intermediary - A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Health Maintenance Organization (HMO) - A type of Medicare Managed Care Plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. In an HMO, you usually must get all your care from the providers that are part of the plan.

Inpatient Care - Health care that you get when you are admitted to a hospital.

Lifetime Reserve Days - Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (\$406 in 2002).

Limiting Charge - The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Long-Term Care - A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care.

Medicaid - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the local area; and
- are not mainly for the convenience of you or your doctor.

Medicare-Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the “Approved Charge.”

Medicare Carrier - A private company that contracts with Medicare to pay Part B bills.

Medicare Managed Care Plan - These are health care choices (like HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan’s list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare + Choice Plan - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare Private Fee-for-Service Plan - A private insurance plan that accepts people with Medicare. You may go to any Medicare-approved doctor or hospital that accepts the plan’s payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Preventive Services - Health care to keep you healthy or to prevent illness. For example, Pap tests, pelvic exams, yearly mammograms, and flu shots.

Primary Care Doctor - A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Managed Care Plans, you must see your primary care doctor before you can see any other health care provider.

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.

Quality Improvement Organizations - Groups of practicing doctors and other health care experts. They are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare Private Fee-for-Service plans, and ambulatory surgical centers.

Referral - An OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Skilled Nursing Facility Care* - A level of care that must be given or supervised by Registered Nurses. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average non-medical person (or one's self) without the supervision of a Registered Nurse is not considered skilled care.

State Health Insurance Assistance Program - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

Telemedicine - The use of medical information exchanged from one site to another using electronic communications for the health and education of patients or providers and to improve patient care.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology® 2000.



Medicare is here for you.

- I'm thinking about joining a Medicare HMO. Which one's best for me?
- I want to buy a Medigap policy. Which one has the extra coverage I need?
- How can I get prescription drug coverage?
- How do I get another Medicare card?
- How do I keep up with what's new in Medicare?
- I can't afford my health care. Can I get help?

Answers to these questions and more are as close as your phone or computer.

- Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, including weekends. TTY users should call 1-877-486-2048. See pages 62-63 to learn how to use this free service.
- Visit www.medicare.gov on the web for quick answers to your questions. See page 61 for more details about Medicare's website.
- Read new booklets about Medicare. See page 64 for details about getting free booklets to help you learn more.



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Important Information about the Next Section

On the following pages, you will find important telephone numbers to help you:

- Page 73 - Find answers to Medicare related questions.
- Pages 74 and 75 - Find out how to get telephone numbers for organizations in your local area that can answer your questions.
- Page 76 - Find the telephone numbers for the Medicare Carrier and the Durable Medical Equipment Regional Carrier for your state or local area. These telephone numbers are the most common referrals we give to callers at 1-800-MEDICARE (1-800-633-4227). We are including them to make it as easy as possible for you to get answers to your Medicare questions.

The telephone numbers listed on the following pages were correct at the time of printing. Sometimes telephone numbers change. You can find the most up-to-date telephone numbers by looking at www.medicare.gov on the web. Select “Helpful Contacts.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Tip: These telephone numbers are busiest early in the week. To cut down on the time you have to wait, it is best to call on Wednesday, Thursday, or Friday.

Important Phone Numbers

Section 10

If you have a Medicare related question, look at the list below to find out where you can call for answers.

Call:

With your questions about:

1-800-MEDICARE

(1-800-633-4227)

24 hours a day

TTY users should call

1-877-486-2048.

- Medicare (in general)
- Medicare health plans
- Ordering Medicare booklets
- Medigap policies
- Prescription Drug Assistance Programs

- Phone numbers for local organizations that work with Medicare, including TTY numbers

Social Security Administration

1-800-772-1213

TTY users should call 1-800-325-0778.

- Address/name changes
- Death notification
- Enrolling in Medicare

- Medicare card (replacement)
- Social Security benefits

Coordination of Benefits Contractor

1-800-999-1118

TTY users should call 1-800-318-8782.

- Which insurance pays first

Department of Health and Human Services Office of the Inspector General

1-800-447-8477

TTY users should call 1-800-377-4950.

- Fraud and abuse

Railroad Retirement Board

1-800-808-0772

- Railroad Retirement benefits
- All other services listed for the Social Security Administration

Department of Veterans Affairs

1-800-827-1000

TTY users should call 1-800-829-4833.

- Veteran's benefits

Department of Defense

1-888-DOD-LIFE (1-888-363-5433)

1-800-538-9552

- TRICARE for life
- Eligibility for military retiree health benefits

Office for Civil Rights

1-800-368-1019

TTY users should call 1-800-537-7697.

- Discrimination

There are many partners that work with Medicare in your local area. The list below explains each organization and the questions they can help you with. To get their telephone number, visit www.medicare.gov on the web and select “Helpful Contacts.” You can also call 1-800-MEDICARE (1-800-633-4227) to get the local telephone number. Listen carefully to the available options at the main menu. TTY users should call 1-877-486-2048.

Organization:

They can answer questions about:

Centers for Medicare & Medicaid Services (CMS) Regional Offices -

Local offices for the Federal agency that oversees the Medicare program.

To report a complaint directly to CMS.

Fiscal Intermediary - A private company that contracts with Medicare to pay Part A and Part B bills for outpatient hospital services.

Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts. They are paid by the Federal Government to check and improve the care given to Medicare patients.

Complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare Private Fee-for-Service Plans, and ambulatory surgical centers, and for questions about your rights as a hospital patient.

Regional Home Health

Intermediary (RHHI) - A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.

Home health care, hospice care, and fraud and abuse.

Organization:

They can answer questions about:

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

Buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, complaints about your care or treatment, help choosing a Medicare health plan, and Medicare bills.

State Insurance Department - A state agency that regulates insurance.

Medigap policies available in your area, and insurance-related questions and problems.

State Medical Assistance Office - A state agency that is in charge of the State's Medicaid program.

Programs to help pay medical bills for people with low incomes, and help with prescription drug coverage.

Note: Remember, if you need one of the telephone numbers listed above, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look at www.medicare.gov on the web. Select “Helpful Contacts.”



Durable Medical Equipment Regional Carrier

Call about:	New York	1(800)633-4227 opt. 1 3 2 (in order)
• Bills for durable medical equipment, including diabetic supplies		
• List of approved suppliers of this equipment		

.....

Medicare Carrier

Call about:	New York Empire Medicare Services	1(800)442-8430
• Part B bills, services, and appeals	Services down-state NY	
• Fraud and abuse	New York Group Health Inc.	1(800)632-5572
• List of participating doctors and providers	(GHI Medicare) Queens county only	
Note: If you get benefits from the Railroad Retirement Board, call the RRB Carrier (Palmetto GBA at 1-800-833-4455).	New York HealthNow of Western New York Services upstate NY	1(800)252-6550

Plan Information for Your Local Area

This part of your handbook contains Medicare + Choice Plan information for your state or area. If you are thinking about joining a Medicare + Choice Plan instead of the Original Medicare Plan, or changing health plans, you should read this section. **Remember, if you are happy with your current health plan, you do not have to change.**

What will I see on the following pages?

You will see a chart of basic information about Medicare + Choice Plans available in your area. Each company that has a contract with Medicare can offer one or more plans. Companies decide where to do business and plans may not be available everywhere. Remember to check with the company and ask if the plan you are interested in is offered in your ZIP code.

How do I read the chart?

Medicare + Choice Plan descriptions and costs are listed by company name on the following pages. Please read the descriptions of numbered items on pages 78-79 and the example on page 80 before turning to page 81 for information about plans available in your area. If “Information Not Available” appears in the charts, Medicare did not get the information in time to print it.

Plan information may change. Get the most up-to-date and detailed information including costs and benefits before you make any change in your health plan. For the most up-to-date information, look at www.medicare.gov on the web. Select “Medicare Personal Plan Finder.” Or, call 1-800-MEDICARE (1-800-633-4227). If you want to talk to someone about your health care choices, call your State Health Insurance Assistance Program (see page 75).



Section 11: Plan Information for Your Local Area

Description of numbered items in example on page 80:

1. **Company Name.** Name of company that contracts with Medicare to offer Medicare + Choice Plans. (The number next to the name is for Medicare's use only.)
2. **Customer Service Number.** Number to call for information about the plan(s) offered.
3. **Approval Status.** Tells you if Medicare has approved the benefits and costs offered by the company for the year 2003. "As submitted by organization" means the company has a current contract with Medicare, but Medicare is still discussing the benefits and costs offered by the company for the year 2003.
4. **Plan Type.** Tells you if this is a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan.
5. **Special Rules.** Tells you if there are special rules for joining this plan.
6. **Quality Measure** (members rating their health care as the best possible). Gives you the results of one question from the Medicare Beneficiary Satisfaction Survey. The question asked plan members to rate the care they had received in six months from all doctors and providers in their own plan, using any number on a scale from 0 (worst possible care) to 10 (best possible care). The results show the percentage of plan members who rated their care as the best (8, 9, 10) on the 1-10 scale. In a few cases, a note will tell you "Not Available" instead of a quality rating. This means the plan was too new to be measured, or the number of Medicare members was too small to report, or Medicare did not require the plan to report this information. For more information about Medicare + Choice Plan quality, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."
7. **Name of the Medicare + Choice Plan.** This is the name of the plan offered by the company that contracts with Medicare. (The number next to the name is for Medicare's use only.)
8. **Plan Service Area.** The local area where the plan is being offered. You must live in this area to join this plan. Check to make sure that your ZIP code is in the plan service area.
9. **Monthly Premium.** Amount you pay each month, in addition to your monthly Medicare Part B premium, when you join the plan. In a few cases, a note will tell you "Under Review" instead of a premium amount. This means Medicare and the company are still discussing the amount.



Description of numbered items in example on page 80 (continued):

10. **Doctor Choice.** Tells you if you must see only doctors who belong to the plan (network) or if you may go out of network.
11. **PCP Copay.** Tells you how much you must pay for each visit to your primary care physician (PCP). If “Under Review” appears, it means that Medicare and the company are still discussing the copayment amount.
12. **Prescription Drug Coverage.** Tells you if the plan covers prescription drugs. If “Yes, for an extra cost” appears, it means you can choose to have prescription drug coverage with this plan, but it will cost you extra. Some plans cover only certain drugs or pay up to a set dollar limit. If the plan covers prescription drugs as part of the plan, you will see the copayment amount for generic drugs. Also, you will see if there is an upper limit for prescription drug coverage in a specific time period. There can be limits on the plan-approved drugs, which is a list of generic, brand name, and/or preferred brand name drugs called the formulary. Also, there may be limits on non-formulary drugs (drugs not on the plan-approved list of drugs). If “Overall” appears, it means that the limit applies to all drugs. If “Unlimited” appears, there is no limit on generic drugs. Plans can make changes in the list of prescription drugs they cover during the year. Call the plan to get all the details of prescription drug coverage so you understand any conditions or limits. If “Under Review” appears, it means that the prescription drug coverage is still being discussed.
13. **Routine Physical Exams.** Tells you if the plan covers routine physical exams. If “Yes, for an extra cost” appears, it means the plan covers routine physical exams, but it will cost you extra. If “Under Review” appears, it means that Medicare and the company are still discussing the routine physical exam coverage.
14. **Vision Services.** Tells you if the plan covers vision services. If “Yes, for an extra cost” appears, it means the plan covers vision services, but it will cost you extra. If “Under Review” appears, it means that Medicare and the company are still discussing the vision services coverage.

EXAMPLE

Maryland								
Company Information	Plan Name	Plan Service Area	Monthly Premium*	Doctor Choice**	PCP Copay	Prescription Drug Coverage***	Routine Physical Exams	Vision Services
ABC Health Plan (H4567) 1 1-888-555-5555 2 Approved by Medicare 3 Managed Care Plan 4 Available to current members 5 Quality Measure 6	Medicare Gold (001) 7	Prince Georges County 8	\$50 9	Network 10	Under Review 11	\$15-\$40 Copay Semi-annual limit (generic, brand non-formulary, preferred brand non-formulary) 12	Yes, for an extra cost 13	Yes, for an extra cost 14

Year 2003 Medicare Health Plans Available in Parts of New York

Some plans may be open to current members only. Please call 1-800-MEDICARE or the health plan to ask if the plan you are interested in is currently accepting new members.

New York

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Doctor Choice**	PCP Copay	Prescription Drug Coverage***	Routine Physical Exams	Vision Services
Excellus Health Plan, Inc. (H3304) Phone Number Not Available Information Not Available Managed Care Plan 50% of members rated their care as the best	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Preferred Care (H3305) 1-585-327-2480 Approved by Medicare Managed Care Plan 51% of members rated their care as the best	Preferred Care Gold (001)	Rochester Area	\$59	Network	\$10	No	Yes	Yes

Call 1-800-MEDICARE (1-800-633-4227) or look on the web at www.medicare.gov for more detailed information, including costs and benefits, about these health plans. TTY users should call 1-877-486-2048.

* This is the amount you must pay each month to belong to the plan. You must continue to pay the monthly Part B premium (\$54.00 in 2002). New Part B premium amounts will be available in January for the year 2003. Some companies may offer extra benefits for an additional cost. This information is available on www.medicare.gov or through 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

** Network means you have to see doctors who belong to the plan. Call the plan to find out if your doctor is a member of the plan.

*** The drug information listed is for the basic drug benefit and for generic drugs only. Some plans offer extra drug benefits for an extra cost. Some plans also cover only certain drugs or pay up to a set dollar limit. Call the plan to get all the details of prescription drug coverage.

New York (continued)

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Doctor Choice**	PCP Copay	Prescription Drug Coverage***	Routine Physical Exams	Vision Services
Healthnow New York, Inc. (H3324) 1-800-329-2792 Contract pending Preferred Provider Organization Rating not available	Medicare PPO 201 Plus (001)	Northeastern New York	\$86.82	In most cases, you may go out of network for higher costs.	\$15	No	Yes	Yes
	Medicare PPO 202 Plus (003)	Northeastern New York	\$166.49	In most cases, you may go out of network for higher costs.	\$10	\$7 Copay Unlimited	Yes	Yes
	Medicare PPO 201 Plus (002)	Western New York	\$108.62	In most cases, you may go out of network for higher costs.	\$15	No	Yes	Yes
	Medicare PPO 202 Plus (004)	Western New York	\$182.88	In most cases, you may go out of network for higher costs.	\$10	\$7 Copay Unlimited	Yes	Yes
Excellus Health Plan, Inc. (H3351) 1-800-558-4320 Approved by Medicare Managed Care Plan 51% of members rated their care as the best	Senior Choice (001)	ALL,CATT,CHAU, ERIE,GEN,NIAG, ORL,WYO	\$34.90	Network	\$5	No	Yes	Yes
	SeniorChoice (002)	ALL,CATT,CHAU, ERIE,GEN,NIAG, ORL,WYO	\$74.90	Network	\$16	\$0 Copay Annual and Quarterly limit (overall)	Yes	Yes
Excellus Health Plan, Inc. (H3356) 1-800-243-2419 Information Not Available Managed Care Plan 53% of members rated their care as the best	Blue Choice Senior (001)	Blue Choice Senior	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
	Blue Choice Senior Low Option (003)	Blue Choice Senior Low Option	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available

New York (continued)

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Doctor Choice**	PCP Copay	Prescription Drug Coverage***	Routine Physical Exams	Vision Services
WellCare Choice of New York (H3361) 1-845-440-2400 Approved by Medicare Managed Care Plan At the time of printing, available to current members only 51% of members rated their care as the best	WellCare Choice Plan (010)	Albany, Greene, and Rensselaer Counties	\$29	Network	\$10	\$15 Copay Monthly limit (overall)	Yes	Yes
	WellCare Choice Plan (018)	Dutchess and Sullivan Counties	\$109	Network	\$10	\$15 Copay Monthly limit (overall)	Yes	Yes
Independent Health (H3362) 1-716-631-8701 Approved by Medicare Managed Care Plan 52% of members rated their care as the best	Encompass 65 (003)	Western New York	\$42	Network	\$5	No	Yes	Yes
	Encompass 65 with 50% Rx Max \$500 (004)	Western New York	\$78	Network	\$10	50% Coinsurance Quarterly limit (overall)	Yes	Yes
Senior Blue (H3384) 1-800-329-2792 Approved by Medicare Managed Care Plan 52% of members rated their care as the best	Senior Blue 402 (013)	Northeastern New York	\$70	Network	\$15	\$7 Copay Unlimited	Yes	Yes
	Senior Blue 403 (014)	Northeastern New York	\$130	Network	\$10	\$7 - \$40 Copay Unlimited	Yes	Yes
	Senior Blue 401 (015)	Northeastern New York	\$35	Network	\$15	No	Yes	Yes
	Senior Blue 402 (019)	Western New York	\$55	Network	\$10	\$7 Copay Unlimited	Yes	Yes
	Senior Blue 403 (020)	Western New York	\$130	Network	\$10	\$7 - \$40 Copay Unlimited	Yes	Yes
	Senior Blue 401 (022)	Western New York	\$0	Network	\$10	No	Yes	Yes

New York (continued)

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Doctor Choice**	PCP Copay	Prescription Drug Coverage***	Routine Physical Exams	Vision Services
CDPHP Medicare Choice (H3388) 1-518-641-3400 Approved by Medicare Managed Care Plan 51% of members rated their care as the best	CDPHP Medicare Choice (001)	Albany,Rensselaer, Saratoga,Schenectady counties	\$35	Network	\$10	Yes, for an extra cost	Yes	Yes

**U.S. DEPARTMENT OF
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To get this handbook on Audiotape (English and Spanish), in Braille, Large Print (English and Spanish), or Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Look at www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get help with your Medicare questions.

¿Necesita usted una copia en español? También está disponible en audiocasete y letra grande. Llame gratis al 1-800-MEDICARE (1-800-633-4227).